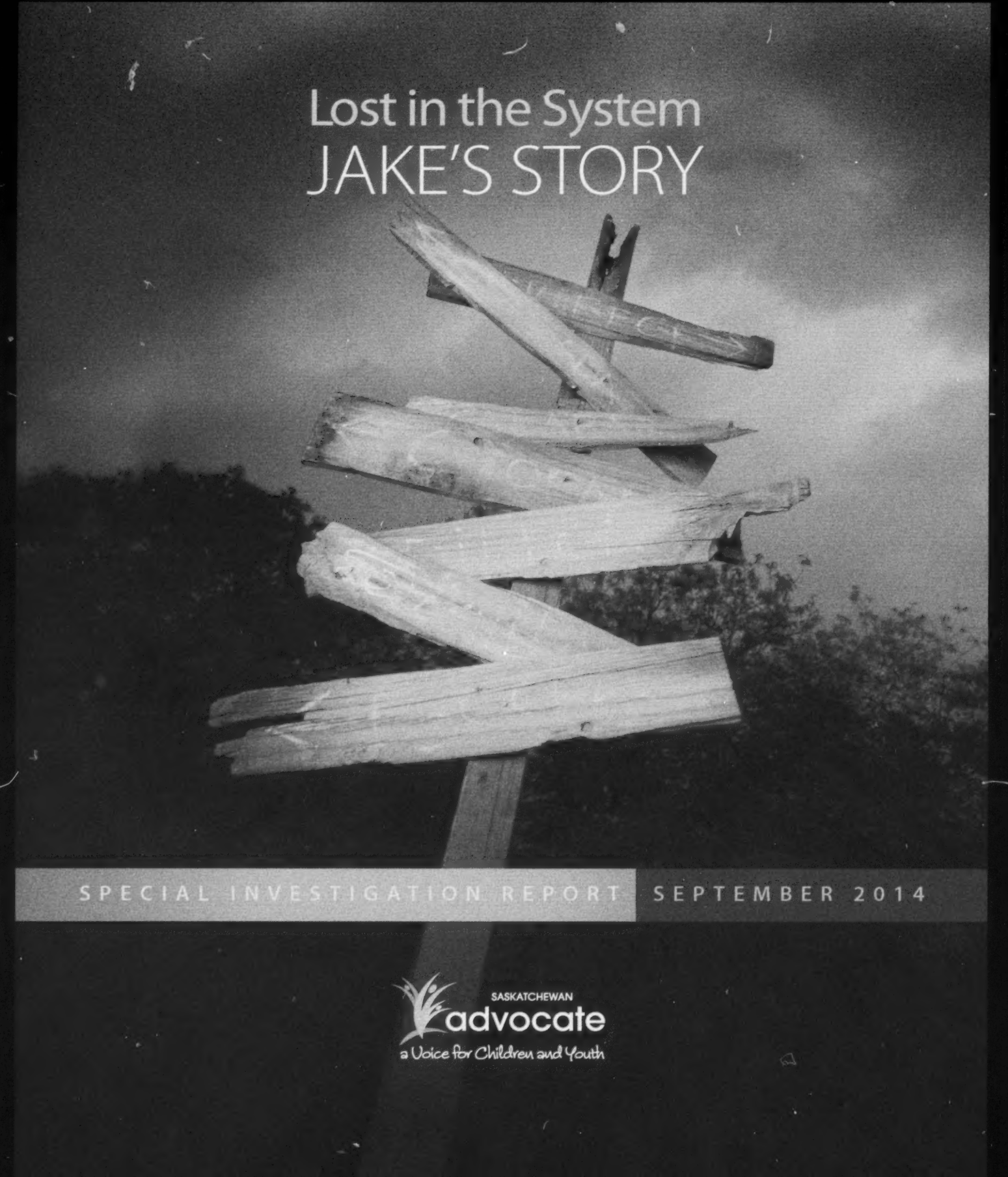

Lost in the System
JAKE'S STORY

SPECIAL INVESTIGATION REPORT | SEPTEMBER 2014

SASKATCHEWAN
advocate
a Voice for Children and Youth

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Letter of Transmittal

September 16, 2014

The Honourable Dan D'Autremont
Speaker of the Legislative Assembly
Legislative Building
2405 Legislative Drive
Regina SK S4S 0B3

Dear Mr. Speaker:

In accordance with Section 29 of *The Advocate for Children and Youth Act*, it is my duty and privilege to submit to you and the members of the Legislative Assembly of Saskatchewan this special investigation report: *Lost in the System: Jake's Story*.

Respectfully submitted,

Bob Pringle

Bob Pringle

Advocate for Children and Youth
Province of Saskatchewan

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To harmonize page numbering between the online and printed version of this report, page numbering has been modified to follow the emerging design standard, with the cover page as Page 1.

This report examines the life of a young child we are calling "Jake," who was in care from the age of five months until his death just prior to his second birthday. As per the legislation governing this office, we have not identified him by his real name. This report includes a review of the services Jake and his family received from the Ministry of Social Services (MSS) and Saskatoon Health Region to determine if they received the services to which they were entitled.

Jake was born a healthy baby on December 14, 2007. His parents had previous involvement with MSS with his older brother, due to his mother's alcohol misuse and domestic violence in the home. While at first things seemed to be going well for Jake's family, within several months of his birth MSS received four reports of his mother's suspected alcohol misuse, one of which was substantiated. On May 13, 2008, when Jake was five months old, he and his brother were taken into care following a domestic dispute in which his mother was allegedly injured by his father, after which she was hospitalized and he was taken into custody.

On May 13, 2008, when Jake was five months old, he and his brother were taken into care

Over the next 10 months, Jake and his brother were moved 11 times, sometimes in short succession. During his time in care, MSS continued to work with Jake's mother, so that she could address her addiction issues and be reunited with her children. While Jake's father was initially involved, later on he refused to participate in case planning and was no longer part of Jake's life.

On March 6, 2009, Jake and his brother were placed in a foster home that was established as an emergency level foster home, meant to care for children for up to two weeks. It had the capacity for 10 emergency placements and two special needs placements, thus considerably exceeding both the maximum number of placements in a foster home (four) and a group home (10).

Jake stayed in this home for the next nine months until his death a few days before his second birthday. On the morning of December 10, 2009, he was found unresponsive when an In-Home Support worker went to wake him up. The day prior, he had appeared to be physically healthy and had been seen by an orthopedic specialist, who confirmed that a fractured femur he had sustained two months prior was healing properly.

The Coroner determined that Jake had died the previous evening, sometime before midnight, although his death was not discovered until the next morning. An autopsy was completed, but neither the cause nor the manner of Jake's death was able to be determined. The Major Crimes division of Saskatoon Police Service investigated Jake's death and found no evidence of foul play.

The purpose of this investigation is to determine whether Jake and his family received the services to which they were entitled, and to make recommendations to improve the capacity of child-serving systems to ensure the rights of children are upheld. It is rare in our investigations that we do not know both how and why a child died. However, this investigation did shed light on the circumstances of Jake's short life and his time in care, prompting a number of recommendations.

Key elements of the report include:

- As required by policy, MSS and the Sturgeon Lake Child and Family Services Inc. conducted a joint child death review of Jake's death in June 2011. The Advocate received a detailed report of this review and agreed with

its 11 findings and 16 recommendations, 14 of which are considered to be completed, with two still ongoing. In the time since Jake's death, there have been many improvements made. They include discontinuing the practice of opening high-capacity homes that are outside of MSS policy, and the introduction of Structured Decision-Making, a new set of tools to better identify and assess risk to children.

- Our investigation found that Jake was vulnerable in many ways due to his young age, the challenges presented by his parents, his inability to talk along with suspected delays in other areas, and his 11 placements during his 19 months in care. His many moves, some of which were not documented sufficiently, were contrary to MSS policy, which states that reasonable steps must be taken to maintain stability in a child's foster home placement and reduce anxiety for the child. These frequent moves during a critical period of his development were detrimental to Jake, and had an impact on his ability to form the kind of loving, stable relationships with caregivers needed for healthy development.
- MSS did not prioritize Jake's developmental health in the management of his case, as they should have when acting as his parent. As a result, many opportunities to address his suspected developmental delays were missed. Throughout his time in care, concerns about Jake's health and development were raised by Public Health nurses, his family physician, an early childhood psychologist, a pediatrician and one of his foster parents, without sufficient follow-up by MSS. A Public Health nurse indicated that he needed a referral for a developmental assessment at Kinsmen Children's Centre when he was six months old and again when he was 20 months old. When Jake died several months later, he still had not been assessed.
- Jake's fractured femur was not investigated adequately, such that it could not be determined if it was an accidental injury or not. This injury occurred while he was placed in a high-capacity foster home that did not have the standards and procedures required to care for children living there safely and appropriately. Although this home provided some stability for Jake, living in this home was not in his best interests as he was a non-verbal child, cared for by many care providers along with many other children.

The purpose of this investigation is to determine whether these children received the services to which they were entitled

The Advocate makes the following recommendations:

- The Advocate recommends that MSS complete a study that includes a review and analysis of the number of moves children and youth experience in out-of-home care and to provide a report to the Advocate. The study should include a random sample of children involved in various types of care in the past two years, the number of moves, rationale for each move and method by which it was approved. A study of this sort should provide MSS with the necessary information to thoroughly understand points of intervention to minimize the number of moves that children experience.
- The Advocate recommends that MSS fully implement the software for the "Linkin" Information Database to allow for data collection to monitor the number of placements of children and youth in out-of-home care provincially.
- The Advocate recommends that the Government of Saskatchewan amend *The Child and Family Services Act* (or any

legislation replacing this *Act*) or its regulations for the licensing of foster homes, to provide accountability for both MSS and for foster parents, improve public confidence and help ensure that the rights, interests and well-being of children are being respected.

This report is intended to restore Jake's voice to the extent possible, so that we can make improvements in child and youth-serving systems for other children

- The Advocate recommends that MSS develop policy for new foster or group home resources that fall outside of the parameters of policy to ensure that Assistant Deputy Minister approval is granted as recommended in the Joint Child Death Review and appropriate operating procedures are developed and implemented prior to the opening of the resource.
- The Advocate recommends that MSS conduct a provincial review of its open foster and group homes as part of the Quality Assurance yearly program review process to ensure that homes are operating as per policy. For those that are operating outside of policy ensure that Assistant Deputy Minister approval is granted, as recommended in the Joint Child Death Review and appropriate operating procedures are developed and implemented.
- The Advocate recommends that MSS amend policy to conduct mandatory investigations of foster home incidents involving highly vulnerable children, including documentation and gathering information from collateral sources such as staff and other children in he home.
- The Advocate recommends that MSS require strict adherence to the "Maximum Number of Children in a Foster Home" and "Foster Home Review" policies in the Children's Services Manual.

This report is called "Lost in the System" as it appeared in this investigation that while Jake's physical whereabouts were known, his needs and best interests were lost as he moved between caregivers, and the many concerns raised about his developmental delays were lost through inadequate case management, inaccurate documentation and a lack of coordination of services. Jake himself did not have a voice, as he had not yet learned to talk when he passed away four days before his second birthday. This report is intended to restore his voice to the extent possible, so that we can make improvements in child and youth-serving systems for other children.

1.1 Circumstances of the Incident

On December 10, 2009, at approximately 7:15 a.m., "Jake," who was almost two years old, was found unresponsive by an In-Home Support worker in his Saskatoon foster home.[1] He was in a playpen, lying face down with his blanket underneath his stomach. When staff attempted to wake him, it was noted that his body was cold. The foster parent picked Jake up to initiate CPR but realized he had been gone for some time. When Emergency Medical Services arrived, he was pronounced deceased.

A post-mortem examination found evidence of minor scrapes and bruises, typical of a child Jake's age. His brain was slightly swollen and the Chief Forensic Pathologist could not determine the reason for the swelling. It was determined that the scrapes, bruises or slight swelling of the brain did not cause Jake's death, and all other factors such as disease or injury were eliminated. As a result, neither the cause nor the manner of death could be determined, and both were listed as "undetermined" on the autopsy report.

The In-Home Support staff reported to police that on the evening of December 9, 2009, Jake was behaving normally, eating and playing. On this evening, there were 10 foster children in the home. Three other children who lived in the home were away on family visits. The children went to bed at 7:30 p.m. At 8:45 p.m., an In-Home Support worker conducted a room check and noted that Jake was awake, lying on his back and blinking his eyes. While Jake's death was not discovered until the morning of December 10, 2009, the Coroner determined he had died the previous evening, sometime before midnight.

The Major Crimes division of Saskatoon Police Service investigated Jake's death and found no evidence of foul play.

Coroner's Classification System - Manner of Death

The Office of the Chief Coroner determines both the cause ("the disease or injury that initiated the morbid events leading directly to death") and the manner of death ("the event or situation which ultimately led to the death, but wasn't actually responsible for the physiological death").[2] The five manners are:

Natural – Deaths due solely or nearly totally to natural disease and/or the aging process.

Accident – When an injury or poisoning causes death and there is little or no evidence that the injury or poisoning occurred with the intent to cause harm or death.

Suicide – Results from an injury or poisoning as a result of an intentional, self-inflicted act committed with intent to do self harm or cause death.

Homicide – When death results from a voluntary act committed by another person to cause fear, harm or death. Homicide is a neutral term and does not imply criminal intent, blame or fault which remains the responsibility of the other judicial processes.

Undetermined – When after completing a thorough investigation, there is no evidence for any specific classification or there is equal evidence, or a significant contest among two or more classifications. If the cause of death is undetermined, then the manner of death is normally undetermined.

1. The In-Home Support Program is administered by the Saskatchewan Foster Families Association. Its purpose is to provide staff to assist foster parents with the daily functioning of homes. Duties for In-Home Support staff can include cooking, cleaning, laundry and some child care and supervision. This report describes the way that the program functioned in 2009, shortly after its establishment as a pilot program in the Centre Region.

2. Government of Saskatchewan. Saskatchewan Coroner's Orientation and Investigative Guide, October 2012, pp. 50-52.

1.2 Mandate of the Advocate for Children and Youth

The Advocate for Children and Youth (the Advocate) is an independent officer of the Legislative Assembly of Saskatchewan. The Advocate has a broad mandate to work on behalf of young people in Saskatchewan under *The Advocate for Children and Youth Act*. The main areas of work consist of advocacy, investigations, public education, and research.

The Advocate felt compelled to tell Jake's story in a public report after learning about his experiences in the child welfare system

The Advocate may give notice of investigation into any matter concerning or services provided to children and youth by a provincial ministry, direct or delegated agency or publicly-funded health entity. The key objectives of an investigation by the Advocate's office are to identify any contributing factors leading to child deaths or critical injuries, and to achieve policy or service delivery improvements through recommendations for consideration by the provincial government.

The *United Nations Convention on the Rights of the Child*[3] guides the work of the Advocate's office. The rights and obligations put forward in the *Convention* have been distilled into the *Saskatchewan Children and Youth First Principles*.[4] The Government of Saskatchewan adopted these principles in 2009.[5] The Advocate also follows the *Touchstones of Hope for Indigenous Children, Youth and Families*,[6] principles that ensure services provided to First Nations and Métis children recognize the child is shaped by his or her traditions, spirituality and social customs. These principles recognize the importance of Aboriginal people providing child welfare services to their communities.

1.3 Purpose, Scope and Methodology

The Advocate is notified and conducts independent assessments and investigations into the deaths and critical injuries of children and youth who, either individually or with their families, were receiving services from government ministries and agencies. Not all of these cases proceed to a full investigation, and of those investigated fully, not all are made public.

The Advocate felt compelled to tell Jake's story in a public report after learning about his experiences in the child welfare system through our investigation. Jake's experiences include being moved many times while in care, concerns about his developmental needs that were not met, and his final placement in an overcrowded foster home that was opened after the release of the Advocate's report *A Breach of Trust: An Investigation into Foster Home Overcrowding in the Saskatoon Service Centre*.[7] While many questions remain unanswered about Jake's injury and how he died, hearing the story of this First Nations child's time in care illustrates that more work is needed to ensure that children, youth and families have access to effective interventions and support services.

This investigation included a review of all available documentation related to Jake's case, inclusive of the Ministry of Social Services (MSS), the Saskatoon Health Region, the Saskatchewan Foster Families Association, the Saskatoon Police Service, and the Office of the Chief Coroner. We also interviewed staff from MSS, Saskatoon Health Region, Saskatoon Police Service, and the In-Home Support staff who were employed in the foster home at the time.

As the In-Home Support Program is operated by the Saskatchewan Foster Families Association, the Advocate also interviewed their Program and Financial Administrator.

The Advocate also contacted the Kinsmen Children's Centre's Alvin Buckwold Child Development Program and the Speech Language Pathology and Audiology programs offered through Saskatoon Health Region to verify whether Jake had received services.

This investigation also considered whether the services provided by MSS adhered to the obligations under *The Child and Family Services Act* (the *Act*). We further considered if the services provided adhered to the principles of children's rights, particularly their rights to safety, protection and well-being.

As part of the scope of this investigation, the Advocate examined the Joint Child Death Review conducted by MSS and Sturgeon Lake Child and Family Services Inc. (CFSI), aspects of which are included in this report. MSS, Sturgeon Lake CFSI, the Saskatchewan Foster Families Association, and Saskatoon Health Region were given the opportunity to review and provide comments on the facts outlined in this report under the principle of administrative fairness, as they had provided evidence. We thank them for their cooperation.

It should be noted that our office was unable to obtain the foster home log book that recorded the day-to-day operations of the home as it was reported to be misplaced. However, at the time of Jake's death, Saskatoon Police Service copied pages from the log book they deemed relevant for their investigation, and later provided copies of these pages to the Advocate.

3. United Nations General Assembly. Convention on the Rights of the Child. 1989. Available at: http://www.unicef.org/crc/

4. Children and Youth First Principles, Saskatchewan Advocate for Children and Youth. Available at: http://www.saskadvocate.ca/children-youth-first/children-youth-first-principles.

5. Government of Saskatchewan. Putting children first: province takes action on child welfare [Press release]. February 25, 2009. Available from: http://www.gov.sk.ca/news?newsId=308e1b59-17ef-47b0-98f1-086003a17fd0.

6. Blackstock, C., Cross, T., George, J., Brown, I, & Formsma, J. Reconciliation in child welfare: Touchstones of Hope for Indigenous children, youth, and families. Ottawa, ON, Canada: First Nations Child & Family Caring Society of Canada / Portland, OR: National Indian Child Welfare Association, 2006. More information on the Saskatchewan Advocate for Children and Youth's adoption of these principles is available at: http://www.saskadvocate.ca/children-youth-first/touchstones-of-hope.

7. Saskatchewan Children's Advocate (former name). A Breach of Trust: An Investigation into Foster Home Overcrowding in the Saskatoon Service Centre. February 2009. Available at: http://saskadvocate.ca/media%20resources%20publications/Special%20Reports

2.1 Family's Involvement with MSS before Jake's Birth

Jake was born on December 14, 2007; his older brother was born in August 2006. In January 2007, Jake's parents became involved with MSS due to a reported concern of alcohol misuse by his mother and domestic violence in the home. At that time, Jake's father had a criminal history that involved impaired driving and violent behaviour and he had recently been released from custody. In addition, this family was facing other challenges including health issues with their first child, whom MSS had referred to as a child with high medical needs. Jake's parents often maintained separate residences.

Jake's mother appeared to be highly stressed with the responsibilities of parenting two young children

Jake's brother was apprehended on two occasions prior to Jake's birth, in February 2007 and again in July 2007, due to ongoing concerns of alcohol misuse and his mother's suicidal thoughts. In both incidents, the parents complied with the case plans and completed the required programming. This included addictions and parenting programming and working with a parent aide. It appeared from the Advocate's investigation that MSS did not require Jake's mother to attend any mental health services to address her suicidal thoughts.

MSS learned in April 2007 that Jake's mother was pregnant with him. That month and again in July 2007, MSS received reports that she was intoxicated during this pregnancy, and she admitted to drinking on one of these occasions.

When Jake's older brother returned after the second apprehension in October 2007, two months prior to Jake's birth, MSS obtained a two-month supervision order, with conditions to cover the last part of their mother's pregnancy.

2.2 Jake is Born

Jake was born a healthy baby with no reported concerns at the time of birth. Royal University Hospital notified MSS of his birth, and MSS advised the hospital social worker that Jake could be discharged to his mother's care given there were no immediate concerns. Jake's mother had advised the hospital social worker that she had support services in place and was involved with *KidsFirst*.[8]

On January 3, 2008, MSS conducted a home visit and reported that the parents were attentive to their children's needs, and appeared to be developing a healthy attachment to Jake. As a result, the Family Services file was closed.

Throughout the month of January 2008, a Public Health nurse had contact with the family on two occasions. On January 23, 2008, the nurse documented that Jake's neck muscle strength was weak. There were no other documented concerns for Jake's health. Jake's mother had described to the nurse her network of supports including Jake's father, *KidsFirst* and child care for Jake's brother.

In February and March 2008, MSS received four reports of suspected alcohol misuse by Jake's mother. MSS investigated these concerns and confirmed one report of alcohol use. The investigation by MSS found that Jake's mother appeared to be highly stressed with the responsibilities of parenting two young children. As a result, MSS made referrals with community agencies to provide support to the parents to deal with stress and their own health issues. The Family Services file was closed as the parents had re-established a safety plan to address any relapses and no further intervention was required.

2.3 Jake Enters Foster Care

On May 13, 2008, the Saskatoon Police Service requested the attendance of the Saskatoon Crisis Intervention Service at a domestic dispute. Jake was in his mother's arms when his father allegedly threw hot water on them. Jake suffered minor burns, and did not require any treatment. His mother sustained more serious burns and was hospitalized for an extended period.

As a result, Jake's father was arrested. Jake and his brother were apprehended by MSS and placed in out-of-home care, as there were no immediate family members residing in Saskatoon who could care for them. Jake's father was charged with assault and a "no contact" order was implemented that prohibited him from attending the family home.

MSS completed its investigation into this incident within 30 days as per policy,[9] concluding that the children were in need of protection pursuant to Section 11 of *The Child and Family Services Act* due to physical harm and domestic violence. The investigation record documented the initial plan for the children, which was for them to remain in out-of-home care for a period of three months, to have their basic needs met, and to maintain contact with their parents. With the exception of their initial foster home placements, Jake and his brother were placed in the same homes throughout their time in out-of-home care.

The Child and Family Services Act

The Ministry of Social Services Child and Family Services Division administers *The Child and Family Services Act*. The purpose of the *Act* is to promote the well-being of children in need of protection by offering services designed to support and preserve the family in the least disruptive manner. The *Act* provides the mandate to investigate reports of child abuse or neglect, and it encourages that services be provided to families in such a way so that children can remain safely in their homes wherever possible. When necessary, children may be removed from the family home when their parents are not able to care for them. The *Act* informs the policies followed by MSS and First Nations agencies.[10]

2.4 Second Move and Initial Planning

On May 15, 2008, five-month old Jake was transferred from the emergency receiving home and placed in a regular foster home. The foster mother reported no significant concerns with his health and development.

In June 2008, Jake's foster mother took him to receive his six month immunizations. At that time, the Public Health nurse was concerned with Jake's gross motor skills as he did not bear weight. Health documentation reflected concerns of Fetal Alcohol Syndrome, noting "Suspect FAS (according to Social Services)"; however, this was not determined concretely. Due to these concerns, she referred him to an early childhood psychologist who worked with Public Health. In addition, the nurse also encouraged Jake's foster mother to obtain a physician referral to the Alvin Buckwold Child Development Program at the Kinsmen Children's Centre for a developmental assessment.

When Jake was six months old, the Public Health nurse encouraged his foster mother to get him referred for a developmental assessment

8. *KidsFirst* is a voluntary provincial government initiative that provides parenting support, mentoring and early childhood development opportunities through home visiting and connecting families with each other, as well as with other support services in their communities.

9. MSS, Family-Centred Services Manual, Sec. 3.1.

10. These policies are included in the Family-Centred Services Manual, the Children's Services Manual and the Structured Decision Making® System for Child Protective Services. Current versions are available from the Government of Saskatchewan's Publications Centre at: http://www.publications.gov.sk.ca/department.cfm?d=17

MSS did not complete an initial Child Assessment and Development Plan to determine Jake's needs and to coordinate the resources identified to meet those needs within the 30 days of coming into care, as required by policy.[11] However, file documentation indicates that an "initial CAD [Child Assessment and Development Plan]" was completed several months after his placement in out-of-home care.

Jake moved six times during his first three months in foster care

During this time, a Parental Services Agreement was made with Jake's mother as per policy.[12] Jake's mother started attending supervised visits with the boys at the MSS office. On August 12, 2008, MSS obtained a three-month temporary order with conditions that the parents participate in case planning to address domestic violence and alcohol abuse, and to increase their parenting skills.

On August 14, 2008, Jake, his mother, and the foster parent attended the first appointment with the early childhood psychologist. On the same day, Jake also attended a doctor's appointment. It was reported that Jake was doing well and no follow-up was required.

2.5 Four Moves in Seven Days

On August 21, 2008, after the boys had been in the home for just over three months, the foster parent requested that they be moved immediately after the worker raised concerns regarding Jake's brother being confined in his room for extended periods of time. They were transported back to the emergency receiving home where they had been placed previously. Jake and his brother were there for one day, and then moved to the Crisis Nursery, a community-based organization that provides short-term child care during an emergency. They only stayed in the Crisis Nursery for one day due to a staffing shortage.

Although Jake had some developmental testing done, there was no interpretation of the results on file and no follow-up by MSS

On August 23, 2008, the children were moved to a regular foster home where they remained for five days before being moved again on August 28, 2008. There was no documentation on file explaining why they were moved from this home. On this date, the children were moved to another regular foster home where they remained for the next four months.

At this point, Jake had moved six times in three months. During this time, file documentation indicates the MSS worker raised concerns with her supervisor as well as the placement unit regarding the number of placements he and his brother had within a short time. There is no documentation to indicate any actions were taken by the supervisor to ensure more stability in Jake's out-of-home placements.

2.6 Planning for the Family and Children

The initial Assessment and Case Plan for the family was completed on September 18, 2008, but not signed off by the MSS worker and supervisor until the end of December 2008. MSS policy states that this initial plan should be completed within 90 days and updated every 120 days after that.[13] In this initial plan, Jake's mother was required to attend addictions counselling, cultural programming through the Sturgeon Lake First Nation's urban office in Saskatoon, and to attend visits and appointments with Jake and his brother. Sturgeon Lake First Nation had been involved with the family since MSS apprehended the children as they were members of this First Nation.

Jake's mother advised the MSS worker that she wanted to work with Jake's father as a family, but she denied that domestic violence was a risk to the children and a barrier in returning them home. In August 2008, the MSS supervisor instructed the worker to make a referral for a parental capacity assessment to inform future case planning for the family. This referral was made in the latter part of September 2008.

In September 2008, the charges against Jake's father for the incident in May 2008 were dropped due to insufficient evidence. On September 23, 2008, MSS and Jake's mother signed another Parental Services Agreement. Jake's father was uncooperative at the meeting with MSS and refused to participate in case planning. Jake's mother did engage in the Parental Service Agreement process, during the course of which she admitted that Jake's father had thrown hot water on her and Jake. This acknowledgement was her first step in accepting that domestic violence was affecting the family's functioning.

On September 28, 2008, Jake's father was arrested and placed in custody after he assaulted Jake's mother, who sustained injuries to her head and eye. She advised the MSS worker that she wanted no contact with Jake's father. Jake's father was no longer involved in his life after this time, and did not participate in any further case planning for him.

As indicated previously, an initial "combined" Child Assessment and Development Case Plan was completed on September 10, 2008. This plan was not signed off by the worker until October 2008, and not by the supervisor until November 2008. This did not comply with policy of completing this planning within 30 days.[14] The plan stated that Jake was assessed as having delays in his gross and fine motor skills and as a result, he was referred to the Kinsmen Children's Centre. However, there is no documentation that MSS had coordinated this referral with Jake's physician. This initial plan also indicated that concerns with Jake's speech resulted in a referral to a speech pathologist. In spite of this, there was no documented assessment information or recordings to confirm that a referral was made.

Jake attended the second and final appointment with the early childhood psychologist on October 14, 2008. Although his health file indicated developmental testing was completed in the areas of cognitive, language, fine motor and gross motor skills, there was no interpretation of the results of these tests on Jake's health file or his MSS files. There was no documentation to indicate that MSS followed up with the early childhood psychologist to obtain information from her assessment to inform case planning for Jake.

2.7 Assessing Jake's Mother's Capacity to Parent

On October 28, 2008, Jake's mother participated in the parental capacity assessment that she had been referred to on September 26, 2008. Jake's father was not assessed as he was no longer participating in planning, as noted above. During this time, Jake's mother completed a parenting course and was attending addictions counseling twice a week. The Sturgeon Lake First Nation urban office facilitated Jake's mother's attendance at parent education and cultural programming. File documentation indicated that MSS intended to reassess the case plan when the parental capacity assessment was complete.

The parenting capacity assessment found that Jake's mother had a serious alcohol abuse problem and needed extensive treatment

The parental capacity assessment, which MSS received in December 2008, recommended that the children not be returned to Jake's mother's care. It found that Jake's mother had a serious alcohol abuse problem, and recommended that she needed one to two years of intensive treatment for substance misuse and domestic violence issues. The assessment also indicated, "she does not appear to have any primary mental health diagnosis" in spite of her history of suicidal thoughts prior to Jake's birth.

11. MSS, Children's Services Manual, Sec. 2.5.

12. MSS, Family-Centred Services Manual, Sec. 5.2.

13. MSS, Family Centred Services Manual, Sec. 2.4.

14. MSS, Family-Centred Services Manual, Sec. 3.1.

The Sturgeon Lake First Nation urban office informed the MSS worker on December 15, 2008, that they had not been able to locate family members who were able to care for Jake and his brother. On December 23, 2008, the MSS worker and Jake's mother discussed the results of her parental capacity assessment. When the worker suggested that she attend a treatment program, Jake's mother responded that she had overcome her addiction.

2.8 Four More Moves over Christmas

Due to a pre-planned period of respite, Jake and his brother moved from their current foster home to the Crisis Nursery on December 23, 2008. The children remained in Crisis Nursery over Christmas. The Crisis Nursery staff advised MSS on December 30, 2008 that Jake and his brother needed another placement because the children were sick. They also advised the MSS worker that the children had little clothing when they arrived, had no car seats, and that Jake's health card had expired in September 2008.

The foster mother was concerned at how many times the children moved during her planned break over Christmas

Jake and his brother were moved to another foster home on December 30, 2008, where they stayed for three days. They were moved again on January 2, 2009, and returned to their regular foster home on January 3, 2009, as the foster mother had returned from respite. During this time, Jake and his brother had moved four times in 11 days. On January 5, 2009, the foster mother raised concerns with MSS regarding the number of times the children had moved while she was on respite.

2.9 Planning with Jake's Parents

At a meeting with the MSS worker in early January 2009, Jake's mother admitted to relapsing with alcohol the previous day. When the MSS worker suggested again that Jake's mother attend a 28-day treatment program, she resisted and would not acknowledge that she had any addiction problems. Jake's mother was advised that MSS intended to obtain another three-month temporary order to continue exploring options for family members to care for the children.

In late January, Jake's father was sentenced to a year in custody for the assault on his mother. She testified against his father in court and described this as being a very difficult process.

The second Assessment and Case Plan for the family was completed on January 30, 2009, but it did not comply with policy as it was not signed off by both the worker and supervisor until March 2009. At this time, Jake's mother appeared to be committed to the case plan and had participated in some programming and addictions counselling. However, relapses remained problematic and there were gaps in domestic violence programming, intensive support for parenting and an extensive addictions treatment program. The case plan was relatively unchanged from the one completed previously.

2.10 Planning for Jake

Jake was examined by a pediatrician on February 3, 2009, due to concerns from his family physician regarding his growth. The pediatrician compared his height and weight from the previous month and was not concerned. However, the pediatrician reported that Jake was "borderline low" on his development and suggested following up in a couple of months.

The second Child Assessment and Development Plan for Jake was completed on January 30, 2009, within the 120-day time requirement. However, it was not signed off by the worker and supervisor until March 2009, contrary to policy requirements. This plan reflected the pediatrician's assessment inaccurately by noting that Jake was overall physically healthy and "developmentally on par." This plan also referenced waiting for the early childhood psychological assessment from Jake's October

2008 appointment, although there was no documentation indicating that any follow-up with Public Health had been done or that the assessment was obtained.

The Child Assessment and Development Plan also indicated that a referral to the Kinsmen Children's Centre was made, but an appointment had not been scheduled, and that the foster parent was responsible for ensuring that Jake was assessed by the Kinsmen Children's Centre team. According to policy, it is the role of case workers to access any necessary resources to meet the needs of children, acting as a designate of the Minister of Social Services, who is considered the child's parent.[15] Once again, it appeared that MSS did not follow up on the referral to ensure that Jake received a developmental assessment at the Kinsmen Children's Centre.

2.11 Eleventh and Final Move

On February 20, 2009, the foster parent advised MSS that Jake and his brother needed to be moved because she was concluding her fostering career. The MSS worker submitted a Placement Referral form to the placement unit.

At this same time, the MSS worker advised her supervisor of the challenges presented by Jake's mother's erratic behaviour regarding relapses and a recent suicide attempt, thus confirming the difficulty of reuniting her with her children. File documentation noted that Jake's mother had recently completed five days of detox and was attending Alcoholics Anonymous meetings. In addition, visits with her children continued to be positive. The worker was instructed to continue with the three-month temporary order and permanency planning with Sturgeon Lake First Nation's urban office in Saskatoon. Jake's mother was to commence programming to address domestic violence and alcohol abuse and to follow through with the recommendations in the parental capacity assessment. Once again, MSS did not require that Jake's mother attend any mental health services to address her suicide attempt.

The MSS worker was advised by the placement unit on March 5, 2009 that several homes had been reviewed but no placements were identified. Later the same day, the unit confirmed that a placement had been located with a foster parent operating an emergency receiving home. Jake and his brother were placed in this home on March 6, 2009. This was Jake's eleventh move since being apprehended.

After the children's placement in the emergency receiving home, the foster parent was concerned that MSS did not provide information to her on the medical needs of the children. This information was given to the foster parent at a home visit several days later, on March 10, 2009.

2.12 Jake's Placement in the Lawson Heights Foster Home

Jake and his brother were placed in the emergency receiving home referred to as the Lawson Heights Foster Home. The In-Home Support worker, who was employed the longest at the Lawson Heights home recalled that "when [Jake] first came he couldn't do anything. After a while he was beginning to walk and he was making sounds but he couldn't talk. He was very small." At the time of this placement, Jake was almost 15 months old.

"when [Jake] first came he couldn't do anything. After a while he was beginning to walk and he was making sounds but he couldn't talk. He was very small."

On April 7, 2009, the foster parent reported to MSS that an In-Home Support worker had dropped Jake twice. As a result, the worker was released from duties at the foster home. Jake was taken to a health clinic for assessment and no concerns were reported. At this time, the documentation indicated that Jake "has been having a lot of tantrums."

15. MSS, Children's Services Manual, Sec. 1.5.

2.13 Permanency Planning

On April 13, 2009, the supervisor directed the MSS worker to apply for an order to make Jake a permanent ward if she was not successful in locating a placement with either extended family or with other members of Sturgeon Lake First Nation. The rationale for permanency was that Jake's mother had not completed programming or treatment to date.

The third Assessment and Case Plan ending on April 30, 2009 complied with policy including signatures by the supervisor and worker. This plan noted that MSS was exploring family options and alternative permanency plans for Jake and his brother. If no placement was located, MSS intended to proceed with a plan for adoption for Jake and his brother. This plan also stated that an updated parenting/psychological assessment was required to determine Jake's mother's progress.

MSS did not follow up sufficiently on the results of Jake's two appointments with a pediatrician and two with an early childhood psychologist

At this time, the risk to the children was rated high based on their ages and the other factors that jeopardized their well-being. There appeared to be little progress from the previous Assessment and Case Plan with the family. The new plan also remained relatively unchanged.

2.14 Continued Planning for Jake

In the third Child Assessment and Development Plan for Jake ending on April 30, 2009, the description of Jake's health and development repeated the same incorrect information. There was no mention that the pediatrician who had assessed Jake in February 2009 had recommended following up in a couple of months. Again it stated that Jake had been referred to the Kinsmen Children's Centre but had no appointment to date. There appeared to be no follow-up by MSS to coordinate the necessary resources to meet Jake's needs.

Jake attended the second appointment with the pediatrician on May 14, 2009. No major concerns were documented; however, the pediatrician ordered an audiology assessment due to a speech delay that was identified at this time. The pediatrician also gave the foster mother a requisition for Hepatitis C Serology to be administered to Jake at 18 months of age, as the need for this test had been raised previously.[16] The Advocate reviewed Jake's health file and did not locate any documentation to indicate that Jake had his hearing tested.

On May 20, 2009, file documentation indicated a staffing issue was brought to the foster parent's attention by MSS that the In-Home Support staff were sleeping at times during the night shift. MSS advised the foster home operator there was to be no sleeping on the night shift and the "staff needed to be doing chores and checking on the children."

2.15 Continued Planning with Jake's Mother

In May 2009, the case plan for the family appeared to shift towards reunifying the children with their mother, rather than adoption, which had been determined a month earlier. MSS obtained a six-month temporary order, the Sturgeon Lake First Nation urban office continued to explore family resources and a referral was made to the Central Urban Metis Federation Inc. (CUMFI) Coming Home Program. Jake's mother completed a 28-day addictions inpatient treatment program and a parenting/psychological reassessment was scheduled for July 30, 2009.

2.16 Jake's Health and Developmental Needs

On August 17, 2009, the foster parent advised the MSS worker that Jake and his brother had hand, foot, and mouth disease. This is a fairly common disease, and the children were reported to be fine.

On August 26, 2009, Jake attended a Public Health Centre for his immunizations. At that appointment, the foster parent expressed concerns that Jake was not meeting developmental milestones. He was 20 months old at this time. The Public Health nurse contacted the Kinsmen Children's Centre who confirmed they had no record of Jake attending their developmental program. The early childhood psychologist and pediatrician were consulted.

On September 2, 2009, the early childhood psychologist advised MSS that Jake needed a physician referral to have his developmental needs assessed at Kinsmen Children's Centre. Although the Advocate confirmed that Jake did not attend any appointments at the Kinsmen Children's Centre, it appears that Public Health was instrumental in contacting MSS to arrange for a referral on his behalf. This occurred 14 months after Public Health had initially identified a need for a referral to Kinsmen Children's Centre.

2.17 CUMFI Coming Home Program

Jake's mother was approved for the CUMFI Coming Home Program, which included 24-hour support and safety planning for her and the children. She moved into a suite on September 30, 2009. In October 2009, Jake's mother continued to have regular visits with her children, graduating from unsupervised daytime visits to overnight visits in her home.

The CUMFI Coming Home Program

The CUMFI Coming Home Program was launched by the Central Urban Metis Federation Inc. (CUMFI) in Saskatoon in March 2009. The program's main goal is to reunite children with their mothers and keep them out of foster care. Coming Home provides emergency and long term housing for single mothers and their children in a safe, caring environment. Mothers are supported with counselling to deal with their health issues and mentored by mentor parents and elders in traditional parenting methods and learning more about their culture. Mothers who have children in foster care are able to have their children visit, and can work with Social Services and staff at CUMFI toward having their children return to their care. The Coming Home Program has three houses, one of which is now open to two-parent families and single fathers.

2.18 Jake is Injured

On October 8, 2009, the foster parent took Jake to see the family physician as he had not been able to stand since the previous day. An X-ray confirmed a fracture of the left femur. The foster parent could not explain how this injury occurred but suggested it may have been caused by roughhousing with the other foster children. A skeletal survey did not reveal any other fractures. The physician advised MSS the injury could have been caused by fairly minimal trauma. At this point Jake was 21 months old.

The foster parent expressed concerns to Public Health that Jake was not meeting developmental milestones

16. Note: The transcription date of this appointment is August 11, 2009.

MSS classified the injury as a serious case incident. MSS staff reviewed the circumstances and determined no investigation was required as the foster parent had responded appropriately to the incident. Instructions were given to the MSS resource worker to review supervision of the children with the foster parent.

The fourth Child Assessment and Development Plan from May to October 10, 2009, also exceeded the 120-day timeline policy.[17] It noted that "a referral is being made to KCC [Kinsmen Children's Centre] to ensure that there are no developmental concerns." There was no mention of the follow-up appointment Jake had attended with the pediatrician and the hearing test that had been ordered at that time. The plan documented that Jake had a fractured femur and the physician was satisfied with the healing.

At 23 months, Jake was still not talking and his behaviour was challenging

2.19 Jake's Mother's Progression

The fourth Assessment and Case Plan for the family from May to October 13, 2009, was not completed within the 120-day timeline policy.[18] In addition to the family's reunification plan, it documented that major changes toward the goals of the case plan had been made by Jake's mother. After completing the 28-day treatment program, Jake's mother's recovery plan consisted of maintaining her appointments with the addictions counsellor and attending weekly Alcoholics Anonymous meetings. She had attended all scheduled visits and the majority of Jake's and his brother's medical appointments. Jake's mother also attended the updated parenting assessment, although the results were not available in time for case planning.

The risk was rated low based on Jake's mother's acceptance into the Coming Home Program which offered significant mentoring support and a safety plan should she have a relapse. MSS planned to increase the visits with Jake and his brother in duration and frequency, which would be monitored to determine when the children could be returned to their mother's care.

2.20 Jake's Final Month

In November 2009, visitation increased to three overnight visits per week at Jake's mother's residence. It was documented that the foster parent was struggling with Jake's behaviour, stating that he yelled constantly and wanted to be picked up. Jake was still not talking. The foster mother expressed her concern that Jake's behaviour would be stressful for his mother.

On November 20, 2009, the Coming Home staff reported to MSS that Jake's mother had relapsed the previous night. The visit scheduled with the children on this day was cancelled. The Coming Home staff felt that Jake's mother had not dealt with her addictions and was not ready for reunification with her children. At this point, Jake and his brother had been visiting each weekend, and MSS had planned to transition the children to her home at CUMFI at the beginning of January 2010.

On December 9, 2009, an orthopedic specialist confirmed that Jake's fracture had healed properly and no follow-up was required.

Sometime before midnight on December 9, 2009, Jake passed away in the Lawson Heights Foster Home. As indicated in Section 1.1, the Coroner could not determine the cause or manner of his death. ◆

17. MSS, Family-Centred Services Manual, Sec. 3.1.

18. MSS, Family-Centred Services Manual, Sec. 5.2.

3.1 The Development of the Foster Home

Jake's placement in out-of-home care occurred during a time when MSS was in crisis regarding the number of children coming into care and the lack of placements available. In a four year period from 2004 to 2008, the Centre Region faced a 62 per cent growth in the number of children requiring foster care.[19] An MSS worker reported, "we had a weekend where we had 15 kids come in. Where are you going to put 15 kids? You're trying the best you can to find the safest environment to put them in."[20]

In response to the placement crisis, MSS developed four homes, each to serve a specific group of children and youth. The home in Lawson Heights was established as an emergency level foster home with residential support, meant to care for children for up to two weeks.[21] The Lawson Heights home had the capacity for 10 emergency placements, and two special needs placements, for children age zero to five years. Consequently, the number of children targeted for placement in this home exceeded the maximum number of children allowed in both a regular foster home (four children) *and* a group home (10 children).[22]

In fact, during a medical appointment with Jake in October 2009, the foster mother reported having 12 children, plus three older children, bringing the total number of children that she was caring for at that time to 15. MSS policy allows for a Service Manager to give approval for the maximum of four children to be exceeded when accommodating emergency placements.[23] MSS obtained the necessary approvals to exceed the maximum number of children for foster homes according to policy.

MSS had the legal authority to establish this resource under the *Act*. MSS and the landlord of the property in Lawson Heights signed the agreement with conditions, in particular that MSS would cover the cost of rent from March 2009 to February 2010. The foster parent was not a party to the rental agreement, which was the case in the other three high-capacity homes. File documentation indicates that she viewed this as unfair.

3.2 The Foster Home Operator

The foster parent for this home was a registered nurse who had specialized training in neonatal rescue. She had previously fostered two children in Edmonton, Alberta, for a period of one year before moving to a small town in Saskatchewan. Once MSS approved her application, she began fostering a child that was placed in her home in October 2008.

Some time thereafter, the foster parent volunteered to manage the Lawson Heights Foster Home. In the process of re-approving this foster parent, MSS was advised by Alberta Child and Family Services that they did not recommend that she care for Aboriginal children. Their letter dated February 12, 2009 indicated that her religious beliefs conflicted with the spiritual beliefs of Aboriginal people. While it is not clear whether the recommendation by Alberta Child and Family Services was discussed directly with the foster parent, the home study that was completed February 9, 2009, before this letter was received by MSS, indicated that the foster parent would be "willing to support a child's need for spiritual development...and maintain the culture of a foster child in her home..." All of the required home and personal checks were completed on the foster parent. With a few exceptions, this foster parent's formal approval was conducted according to policy.[24]

"we had a weekend where we had 15 kids come in... you're trying the best you can to find the safest environment to put them in."

This investigation found that the foster parent did not just provide two-week emergency foster care as some of the children, such as Jake and

19. MSS, Centre Service Area Response to Child Death Review Draft Report.

20. Interview with Supervisor, Placement Unit, MSS, Saskatoon, SK, February 4, 2013.

21. Interview with Service Manager, MSS, Saskatoon, SK, May 1, 2013.

22. MSS, Children's Services Manual, Sec. 4.4.7; MSS, Residential Services Manual, Sec. 1.7.

23. MSS, Children's Services Manual, Sec. 4.4.7

24. MSS, Children's Services Manual, Sec. 4.4.1

his brother, were placed there for extended periods of time. The foster parent's responsibilities included transporting the children to family visits, to school and to emergency and scheduled medical appointments. In addition, the foster mother was handling all the grocery and other shopping for the household, as well as overseeing repairs to the property.

3.3 The In-Home Support Program

In response to the placement crisis, the In-Home Support Program was piloted in 2008 in the Centre Region and was administered by the Saskatchewan Foster Families Association. The purpose of the In-Home Support staff was to assist in the daily functioning of the home, leaving the foster parent with more time for the children.

This foster home exceeded the maximum number of children allowed in a foster home *and* a group home

The number of In-Home Support hours a foster home qualified for was based on the number of children placed in the foster home. Due to the exceedingly high number of children, the Lawson Heights Foster Home qualified for the maximum of 245 daytime hours and 56 nighttime hours of support per week. In addition, the resource unit increased contact and support to the foster parent who also had access to a 24-hour call line.

The In-Home Support staff were hired according to MSS standards, which includes criminal record, child abuse, and reference checks. The duties of the In-Home Support staff working in the Lawson Heights home were cooking, cleaning, laundry, and supervision and care of the children. The Saskatchewan Foster Families Association advised the Advocate that they did not offer training for In-Home Support staff during this time and that MSS was responsible for any additional training that may be required.

The Saskatchewan Foster Families Association also advised the Advocate that foster parents are "the direct supervisors to these employees. They handle the scheduling and they handle their own duties within their home." The In-Home Support staff interviewed by the Advocate indicated that the Lawson Heights home was well-run and the foster parent "was always around if we needed her." However, in spite of this, they felt she was overburdened with a myriad of responsibilities in operating the home and meeting the needs of the children in her care. This was corroborated by information documented in May 2009, which indicated the foster parent had advised the MSS worker that she may be burning out.

3.4 Standard Operating Procedures

MSS provides a continuum of out-of-home care for children and youth. Specialized resources such as group homes, therapeutic homes and assessment/stabilization homes are guided by policies in the Residential Services Manual. This manual clearly states that each program must develop its own local policy and procedures manual and highlights areas in which there should be policy development. Interestingly, this manual speaks to these specialized resources providing care for "4 to 10 children."[25] As previously mentioned, with approval for 12 children, the Lawson Heights Foster Home was approved for more children than the group home policy allows. Although the Lawson Home was set up as an emergency foster home, one MSS worker acknowledged that in practice it operated like a group home.

Several of the standard operating procedures of the Lawson Heights home were established by the foster parent with the help of the MSS placement unit. An In-Home Support worker advised the Advocate there was a binder that contained a description of their duties. In addition, there was a log book that staff used to communicate with the foster parent and each other upon arrival for work. In-Home Support staff reported to the Advocate that they were expected to review it and to use it to document important information from their shift such as the administration of medication to a child.

The two main areas where MSS operating procedures appear to be inadequate were incident reports and room checks. This investigation found no standards beyond the regular foster home standards for reporting incidents in the home. In general, foster parents are required to advise MSS "immediately of any illness, accident, injury, or extraordinary event or incident concerning the child."[26]

The foster home file had one incident report from March 2009, in which the foster parent described an incident where a child ingested Advil. The report included the time of the incident, the time the child was transported to the hospital and the monitoring of the child upon return to the foster home. This was the only incident report found regarding an incident involving a child in the home.

In April 2009, the foster parent advised MSS that an In-Home Support worker had dropped Jake on two occasions. The information was found in a contact note which lacked important details such as the dates and times of the incidents.

The In-Home Support staff were not required by MSS to provide incident reports and there were no reports from them regarding Jake's fractured femur. While Jake's injury may not have been witnessed by the In-Home Support staff, any supplementary information about his activities in the days prior to the discovery of the injury could have shed further light on how this incident occurred. The foster parent was often away from the foster home to fulfill numerous responsibilities, which meant that care and supervision of the children largely fell to the various In-Home Support staff. Consequently, proper standards for identifying and reporting incidents are an important requirement in a home of this size, along with the training to enable staff to meet these standards.

Similarly, standards were lacking for conducting and documenting room checks. None of the MSS foster home policies require room checks. However, there is a reference to room checks in the Residential Services Manual indicating that group homes need procedures to describe the frequency of bedroom checks.[27] File documentation indicates that staff working at night conducted hourly room checks which consisted of a general observation of the room. In-Home Support staff that worked at night were not required to check each child specifically, or document the time each room check occurred. The Coroner determined that Jake died prior to midnight on December 9, 2009, but that his death was not discovered until 7:15 a.m. the next morning. This raises questions as to the purpose of room checks generally, how staff were conducting room checks at night, and the policy required in a resource with this many children. ◆

The two main areas where MSS operating procedures appeared to be inadequate were incident reports and room checks

25. MSS, Children's Services Manual, Sec. 4.4.1

26. MSS, Children's Service Manual, Sec 12.12

27. MSS, Residential Services Manual, Sec. 6.7

As is required by policy, MSS and Sturgeon Lake CFSI conducted a Joint Child Death Review of Jake's death in June 2011. The Advocate received a detailed report of this review on February 7, 2012. The Advocate found this review to represent a comprehensive assessment of the services provided by MSS to Jake and his family; however, it was also determined that its scope was limited as it did not explore the external services provided in a thorough manner.

Several of the pertinent issues examined in the Joint Child Death Review were also identified in the Advocate's investigation. The Advocate agrees with the 11 findings from the review and acknowledges the in-depth explanations and supporting evidence for each finding.

The Advocate agrees with the 11 findings and 16 recommendations from the Joint Child Death Review

The Advocate also agrees with the 16 recommendations of the Joint Child Death Review. These recommendations are summarized below.

- An approval process for all new projects to meet the foster home guidelines and group home standards including:
  - new projects falling outside the provisions of guidelines or standards must be approved by the Assistant Deputy Minister;
  - operating guidelines/standards are established prior to opening; and
  - staff training for both current and new foster and group homes.
- A review of all emergency receiving foster homes in the Centre Service Area to specifically:
  - identify numbers and ages of the children in these homes; and
  - ensure policy compliance and standards are being met.
- Training for culturally sensitive care, and suitability of placement of children in foster homes who are of Aboriginal ancestry.
- Implementation of review processes to assess quality of care issues and of contact standards related to:
  - unannounced visits to the home;
  - the investigations of incidents such as the injury Jake sustained;
  - locked basement bedrooms; and
  - sleeping arrangements in foster homes.
- Training for Ministry staff and foster parents on the impact of repeated moves on children, to include the negative impact of moves on forming attachments that are crucial for successful outcomes for children in care.
- Improving case management practices to include:
  - recording and proper documentation of family service involvements on electronic databases;
  - documenting supervisor consultation;
  - documenting rationale for changes to case plans and placements;
  - making unannounced visits to foster homes; and
  - assigning responsibility for follow-up after a child death review.
- Joint involvement of First Nations agencies in case planning for band members who are in MSS care provincially.
- Joint involvement between the First Nation agency of the child and the Ministry of Social Services in the child death review process.
- The development and financial support of the In-Home Support Program provincially with specific policy development on:
  - clarity of roles and responsibilities; and
  - process for information sharing and "duty to report."

- The development of a process for communicating results of a child death review and actions that emerge from it.

MSS developed an Action Plan in response to the Joint Child Death Review recommendations. The Advocate received a progress update in July 2014 which is summarized below. The progress report noted that 14 of the 16 recommendations are considered to be completed, while two are identified as "ongoing."

Since the Joint Child Death Review, MSS conducted several program reviews of the services provided by, and the resources in, the Centre Service Area. The program reviews conducted between 2010 and 2013 confirmed that there was:

- an increase in contacts between workers and foster parents;
- a reduction in the number of foster homes which were over capacity; and
- an increase in appropriate MSS follow-up regarding foster home quality of care issues.

The MSS Quality Assurance Unit conducts annual reviews of each of its Service Areas to measure compliance with policies and practices. The unit also conducts reviews of all critical injuries and child deaths. Recommendations from these reviews are shared and action plans developed to address any presenting concerns.

In the years since Jake's death, the Advocate notes that many program improvements have been made. Of utmost importance is that the practice of opening high-capacity resources has been discontinued. All current resources are classified as either a foster home or a group home, thereby being covered by MSS policies currently in place. In addition, the following have been implemented:

- Structured Decision Making, a new case management model inclusive of risk identification;
- a new electronic database for documenting and sharing of information;
- foster parent training updates including sessions on cultural sensitivity, loss and attachment;
- MSS staff training updates to include critical thinking related to case management decisions, documentation, child development, and staff roles and responsibilities;
- policy revisions pertaining to foster home physical space, health and safety requirements, serious occurrences in foster homes, and household support for foster families;
- a supervision tool to increase quality of supervisor oversight; and
- Assistant Deputy Minister approval for new projects.

The Action Plan also focuses on MSS prioritizing its partnerships with First Nations bands and Child and Family Service agencies. The MSS Family Connections Planners and Family Finders work to find placements with extended family or members of the same band, and policy requires the involvement of First Nations bands and agencies in all case planning, and all child death and critical injury reviews. As work with First Nations bands and agencies continues to evolve, tasks pertaining to two of the recommendations on the Action Plan are ongoing.

In the years since Jake's death, many program improvements have been made

MSS considers the above items sufficient to address the specific concerns outlined in the Joint Child Death Review, resulting in action plans being completed for 14 of the recommendations. Increased accountability, oversight, consistency, and critical thinking in planning for children in care, and development of a risk assessment and case management model are noted by the Advocate to be significant improvements in providing better services for children in care. ◆

Jake was a First Nations child who was vulnerable in many ways due to his young age, the challenges presented by his parents, his inability to talk and suspected delays in other areas, as well as his multiple placements during his 19 months in out-of-home care. MSS had intermittent involvement with the family dating back to January 2007. In May 2008, five-month old Jake and his 21-month old brother were apprehended from their parents and placed in out-of-home care after an incident reflecting domestic violence and alcohol abuse. MSS had the legal authority to place Jake in out-of-home care, and this decision was appropriate and in compliance with applicable policies and procedures.

Jake's needs were not prioritized at a crucial time in his development

The investigation found that Jake's needs were not prioritized at a crucial time in his development. Jake's case planning was characterized by frequent moves, inaccurate information and a lack of coordination of services. Also evident was the failure to assess what appeared to be significant delays in his development that were documented as raised numerous times by health care providers and one of his foster parents.

Numerous placements can impede healthy attachment to caregivers and interrupt the emotional nurturing required for optimal brain development in young children such as Jake. This was contrary to the change of placement policy and accordingly, not in Jake's best interests as defined by *The Child and Family Services Act* and the *Saskatchewan Children and Youth First Principles*.

Jake's and his brother's placement in the Lawson Heights emergency receiving home did not correspond with the direction taken by MSS to obtain a permanent order. Jake and his brother were among the 10-15 children residing in this foster home at any given time. MSS applied regular foster home standards to the Lawson Heights home which the Advocate's investigation found to be inadequate, given the home was meant for 12 children from birth to age five, two of whom would be children with special needs.

The Advocate recognizes that MSS attempted to mitigate the significant responsibility of the foster parent to operate this home by providing In-Home Support staff at the maximum number of hours allowed. However, the method by which In-Home Support was operational in this foster home was not always clear.

The findings below highlight the need for MSS to critically examine how children move through the system, including effective case planning that incorporates targeted resources from other child-serving systems to meet the needs of children in out-of-home care.

Finding #1: ***Jake's experience in out-of-home care, particularly 11 moves in less than 10 months, reflected significant disruption and unpredictability, which was detrimental to his overall health and well-being.***

In the months following his apprehension, Jake moved 11 times. MSS and the Agency identified this as an issue in the Joint Child Death Review, which stated that "[m]ultiple moves for children in care are a concern provincially." However, MSS advised the Advocate that its information database, Linkin, has limited ability to report the number of successive placements for a child in out-of-home care. MSS is currently developing more comprehensive reporting capabilities to better track, on an aggregate level, the number of moves children experience.

The multiple placements that Jake experienced are contrary to MSS's change of placement policy which states that reasonable steps must be taken to maintain stability in a child's foster home placement to reduce multiple moves and anxiety for the child.[28] In August 2008, file documentation indicates the MSS worker recognized the multiple moves Jake experienced in a short timeframe were not in his best interest and did not support his well-being. In January 2009, his foster parent at that time expressed the same concerns. These were reported to the supervisor, however no effective action was taken.

Article 25 of the *United Nations Convention on the Rights of the Child* acknowledges the rights of children who require care, protection or treatment to have periodic reviews of their circumstances. Article 25 is one of the most important rights for children "because it provides safeguards against one of the most serious forms of child abuse—abuse by the State."[29] In consideration of the best interests of the child principle, MSS must adopt a higher standard of review and monitoring of children's situations to minimize multiple foster home placements. This standard would be difficult to achieve, however, without the data reporting capacity.

The National Scientific Council on the Developing Child, based at Harvard University's Center on the Developing Child, notes that traditional child welfare systems in North America prioritize a focus on children's physical safety, not on that of their healthy development. Several decades of research on the science of early childhood development has firmly established that young children experience the world "as an environment of relationships, and these relationships affect virtually all aspects of their development – intellectual, social, emotional, physical, behavioural and moral."[30]

28. MSS, Children's Services Manual, Sec. 2.8.

29. United Nations Children's Fund. Implementation Handbook for the Convention on the Rights of the Child. Fully Revised Third Edition, 2007, p. 379. Available at: http://www.unicef.org/publications/files/Implementation_Handbook_for_the_Convention_on_the_Rights_of_the_Child.pdf

30. National Scientific Council on the Developing Child, Center on the Developing Child at Harvard University. (2004). Young children develop in an environment of relationships. Working Paper No. 1, p. 1. Available at: http://developingchild.harvard.edu/resources/reports_and_working_papers/working_papers/wp1/

31. Center on the Developing Child, Harvard University. When should we worry about toxic stress? In Key Concepts: Toxic Stress. Available at: http://developingchild.harvard.edu/index.php/key_concepts/toxic_stress_response/. See also: National Scientific Council on the Developing Child. (2005/2014). Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper 3. Updated Edition. http://www.developingchild.harvard.edu

32. Center on the Developing Child, Harvard University. In Brief: the impact of early adversity on children's development. [fact sheet]. Available at: http://developingchild.harvard.edu/index.php/resources/briefs/inbrief_series/inbrief_the_impact_of_early_adversity/

The effects of stress on children's development

Learning to cope with stress is a normal part of a child's development. Stable, caring relationships are critical for children to learn to cope with stressful events. Scientists at the Center on the Developing Child at Harvard University characterize a child's response to stress in three ways: positive stress, tolerable stress and toxic stress. If children have the loving care of supportive adults, they can recover quickly from situations causing a positive stress response quickly, such as getting an immunization, and situations causing a tolerable stress response, such as a serious injury or death of a parent, without lasting damage.

Stress can become toxic to children when they are exposed repeatedly to adversity, such as abuse, neglect or family violence, and adults are unresponsive or inconsistent, so that they do not buffer the child's response to these stressful events. It can damage the architecture of the child's developing brain, which can result in life-long issues with learning, behaviour and physical and mental health. While remediation efforts can help later on, research has shown that it is much more effective to intervene early to reduce and prevent this kind of stress, as its impact can persist long after children have been removed from stress-inducing situations.[31]

Jake was apprehended from a chaotic environment in which he was exposed to situations that could cause a toxic stress response, to another unstable environment, as he moved frequently between caregivers, sometimes in short succession. While he did experience some stability in his final placement, he was still cared for by many caregivers alongside many other young children. His ability to form attachments with stable, loving caregivers was disrupted by these frequent moves.[32] Concerns were raised regularly about his development, suggesting that the repeated exposure to experiences causing a toxic stress response was having a detrimental effect on him.

Jake's moves:

May 13, 2008: apprehended at hospital
May 14, 2008: placed in emergency receiving home (one day)
May 15, 2008: moved to regular foster home (three months)
August 21, 2008: moved to emergency home (one day)
August 22, 2008: moved to Crisis Nursery (one day)
August 23, 2008: moved to regular foster home (five days)
August 28, 2008: moved to another regular foster home (four months)
December 23, 2008: pre-planned respite period - moved to Crisis Nursery (seven days)
December 30, 2008: moved to another respite placement (two days)
January 2, 2009: moved to another respite placement (one day)
January 3, 2009: moved back to regular foster placement (two months)
March 6, 2009: moved to high-capacity emergency foster home (nine months)

Extensive research on how children's brains develop has proven that the quality of their relationships with their caregivers during the time period of zero to three, while their brains are developing rapidly, sets the foundation for their health and well-being throughout the rest of their lives. While young children can and do establish healthy relationships with more than one or two adults, researchers have identified that "prolonged separations from familiar caregivers and repeated 'detaching' and 're-attaching' to people who matter is emotionally distressing and can lead to enduring problems."[33]

In light of this research, it appears that Jake's many moves between caregivers had an unfavorable effect on his development.

Jake was slow to hit developmental milestones like crawling and walking, and he never learned to talk

Finding #2: ***While the case planning for Jake's mother addressed many of her needs, planning for Jake was deficient and did not meet his developmental needs.***

MSS provided timely referral and access for Jake's mother to receive the parental capacity assessment. The acceptance of Jake's mother into the supportive living offered by the Coming Home Program occurred due to the persistent coordination efforts of the MSS worker. In consideration of Jake's mother's progress toward the goals of the case plan, MSS increased the duration and frequency of her visits with the children. One of his mother's strengths was her significant commitment to her children, in spite of her own complex needs. Additionally, Sturgeon Lake First Nation urban office demonstrated a commitment to Jake and his family by participating in the case planning for his mother, including providing cultural programming and identifying potential family resources to care for him.

However, some services to Jake's mother were deficient, as they were not consistent with the recommendations of the parental capacity assessment. Jake's mother received various short-term interventions for her addiction issues, but not a long-term program as suggested. It should be noted that Saskatchewan does not have any resources which provide one to two years of intensive addictions treatment. Jake's mother did not receive any assessment or services following her suicide attempt. The lack of intensive treatment specific to her needs may have contributed to Jake's mother's continued relapses and ability to parent her children effectively.

The Sturgeon Lake CFSI and MSS Joint Child Death Review did not fully examine whether the services provided met Jake's health and developmental needs. Jake intersected with the health care system no less than 26 times during his short life. It appeared that Jake received appropriate health care at his birth, at times of illness and in the treatment and monitoring of his fractured femur. Public Health reported to the Advocate that Jake's immunizations were up-to-date. This investigation found that while it appears Jake's physical health needs were met, concerns about his overall development were not prioritized adequately by MSS.

An initial assessment of Jake's developmental needs did not occur as directed in policy.[34] Furthermore, Jake's Child Assessment and Development Plans were not consistently completed within the timelines as stated in policy.[35] Several plans had lengthy delays between completion and the worker and supervisor sign off. In addition, these documents often contained inaccurate information about Jake, his needs and the status of his development. The follow-up by MSS with service providers on important services Jake required was inadequate.

Policy states that it is the responsibility of MSS case workers as the designate of the Minister of Social Services, to act in the role of parent to a child, and to act with the child's best interests as the primary focus. This includes accessing any resources required to meet a child's needs. The Advocate found that MSS did not prioritize Jake's developmental health in the management of his case, even though concerns about Jake's health and development were raised by the

Concerns about Jake's development

During Jake's 19 months in care, issues about his health and development were raised numerous times with inadequate follow-up.

Mid-June 2008 (age six months): A Public Health nurse raised concerns about gross motor skills. She referred Jake to an early childhood psychologist working with Public Health and told the foster mother he needed a physician referral to be assessed at Kinsmen Children's Centre. File documentation from Public Health noted "Suspect FAS (according to Social Services)."

August 14, 2008 (eight months): The early childhood psychologist saw Jake, reviewed his history and had his mother fill out a developmental assessment.

October 2008 (10 months): The early childhood psychologist did developmental testing in the areas of cognitive, language, fine motor and gross motor skills, but did not report on the results of these tests, and MSS did not follow up further.

February 3, 2009 (almost 14 months): Jake's family doctor referred him to a pediatrician due to a concern about his weight. The pediatrician was not concerned about Jake's weight, but noted that he was "borderline low" on his development, and suggested a follow-up in several months.

March 6, 2009 (almost 15 months): Jake was placed in the Lawson Heights Foster Home. In an interview with the In-Home Support worker who worked there the longest, she said, "When he first came he couldn't do anything. After a while he was beginning to walk and he was making sounds but he couldn't talk. He was very small."

April 7, 2009 (almost 16 months): Jake was seen at a Public Health clinic as an In-Home Support worker had dropped him twice. While there were no documented concerns regarding the falls, it was stated that Jake was crawling and "has been having a lot of tantrums."

Mid-May 2009 (17 months): At the follow-up appointment, the pediatrician did not note any major concerns other than ordering a hearing test to see why he was not talking. The Advocate found no indication that this hearing test was ever done.

August 26, 2009 (20 months): At an immunization appointment at a Public Health clinic, his foster mother told the nurse that she was concerned about delays in Jake's development. The nurse determined he had never gone to Kinsmen Children's Centre for assessment, followed up with the pediatrician, and had the early childhood psychologist advise MSS that Jake needed to be assessed at Kinsmen Children's Centre. While there is some indication that this referral was being made, Jake was not seen at the Centre before his death.

November 20, 2009 (23 months): The foster parent was struggling with Jake's behaviour, saying he yelled constantly and wanted to be picked up, and she was concerned it would be stressful for his mother to manage on overnight visits.

Public Health nurse, family physician, an early childhood psychologist, a pediatrician, and one of his foster parents.

Jake was slow to hit developmental milestones like crawling and walking, and his language development was delayed, as he never learned to talk. During his time at the Lawson Heights Foster Home, it was reported Jake had many temper tantrums, banged his head on the floor, yelled frequently, and wanted to be held regularly.

33. National Scientific Council on the Developing Child, Center on the Developing Child at Harvard University. (2004). Young children develop in an environment of relationships. Working Paper No. 1, p. 3. Available at: http://developingchild.harvard.edu/resources/reports_and_working_papers/working_papers/wp1/

34. MSS, Children's Services Manual, Sec. 2.5.

35. MSS, Children's Services Manual, Sec. 2.5.

File documentation indicated that a pediatrician had ordered a hearing test for Jake when he was 17 months, but this was never done. A Public Health nurse indicated that he needed a referral for a developmental assessment at Kinsmen Children's Centre when he was six months old and again when he was 20 months old. When he died, only a few days from his second birthday, he still had not been assessed.

This is a significant delay during a critical period in the life of a developing child and indicates that MSS was not providing the oversight needed to manage Jake's healthy development. MSS knew that Jake's mother had been drinking while pregnant with him and that he spent his first five months with parents who had challenges with substance use, domestic violence, extreme parental stress, and mental health. Additionally, concerns were raised regularly by health care providers and foster parents regarding his developmental needs. MSS should have prioritized Jake's case plan related to the developmental assessments required in order to better identify and meet his needs.

the high number of children, their needs, and the level of responsibility was taking a toll on the foster parent

Article 24 of the *United Nations Convention on the Rights of the Child* recognizes a child's right to a high standard of health, including access to facilities to address their needs. Article 24 adds, "State Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services." Jake's right to adequate services was not prioritized; in fact, it was seriously compromised.

Finding #3: ***There was inadequate investigation regarding the fractured leg that Jake sustained during his placement at the Lawson Heights Foster Home.***

The Advocate agrees with the Joint Child Death Review that when Jake's injury was identified, the foster parent's action was appropriate to ensure that he received timely diagnosis, treatment and follow-up by medical professionals. However, file documentation revealed three different explanations for Jake's injury from the foster mother, which is concerning given this is found to be one of several red flags indicative of non-accidental injury.[36]

The Advocate also agrees with the Joint Child Death Review finding that, as part of the investigation, both the In-Home Support staff and the other children in the home should have been interviewed to provide more information on how this incident occurred.

The unexplained injury that Jake sustained was not the first unexplained incident that had occurred in the Lawson Heights Foster Home. In June 2009, Jake's brother arrived at a visit with their mother with a black eye. The foster parent indicated it had happened the previous week, but details of how it occurred could not be located on the MSS file. Later this same month, an MSS worker reported to the placement unit that another child in the Lawson Heights home had attended a home visit with a big red mark and small cut under his eye. The foster parent had no explanation and it appeared she did not notice the injury before the child's mother pointed it out.

Article 20 of the *United Nations Convention on the Rights of the Child* speaks to the special protection and attention that children are entitled to when they are deprived of their family environment.[37] Jake would have been better served had there been a thorough investigation to examine whether his injury was accidental or not. In addition, a thorough investigation would have provided the opportunity to examine and discuss other incidents in the home.

Finding #4: ***A high-capacity foster home with placements for 12 children was established with MSS and In-Home Support, but without the commensurate operational standards.***

There appeared to be no standards beyond the regular foster home standards for reporting and documenting incidents occurring in the home to MSS. Proper standards for reporting and documenting incidents are critical in an environment in which several workers interact

around the clock with 12 or more young children with a range of needs, as is the corresponding training to enable staff to meet those standards.

There was no information to suggest that standards for In-Home Support staff to complete regular checks on the children had been developed. The information from the In-Home Support staff themselves was inconsistent regarding room checks.

Higher standards and procedures were required to adequately operate a resource caring for this many children and provide an equitable standard of care to Jake and the other children living there.

As indicated in Article 19 of the *United Nations Convention on the Rights of the Child*, States Parties shall take all appropriate measures to protect children from injury, abuse and maltreatment. MSS was responsible for the children in the Lawson Heights home and for ensuring that appropriate operational standards were implemented. The lack of adequate standards hampered MSS's ability to monitor, identify, and problem solve when issues arose in the home before they became serious, such as children having unexplained injuries.

Finding #5: ***The establishment of the Lawson Heights Foster Home for 12 children was inappropriate, and not in the best interests of Jake and the other children placed there.***

There is limited documentation to indicate to what extent MSS complied with placement selection standards prior to placing Jake in the Lawson Heights Foster Home. All the pertinent factors were not adequately considered by MSS, such as the type and intensity of care required by the child, ages and number of the other children in the home, and the level of skill of the caregiver.

Alberta Child and Family Services had recommended that the foster parent was not an appropriate caregiver for Aboriginal children based on her spiritual beliefs. This was new information provided after the home study was completed. The Joint Child Death Review recommended that in cases where new information comes to light regarding the capability of a caregiver to meet the needs of children in their care, a formal review be conducted to determine the suitability of further placements. The Advocate agrees with this recommendation.

Although the Lawson Heights home provided some stability to Jake and his brother in contrast to the multiple placements that they had experienced previously, placing these children in a foster home with an extremely high number of young children was inappropriate. Jake was a non-verbal child who was placed in a high-capacity foster home and was one of many children cared for by several care providers. MSS provided some support through the In-Home Support Program. However, this placement was not in Jake's best interests, as it did not provide the optimal conditions required for consistent emotional nurturing necessary for young children's healthy development.

In addition, it appears the high number of children, their needs, and the level of responsibility was taking a toll on the foster parent. The In-Home Support staff reported that she was overburdened with numerous responsibilities regarding the operation of the home and meeting the needs of the staff and children in her care. ◆

36. Radesky, J., and Sugar, N., noted that red flags for abuse include: an unwitnessed trauma; an absence of history of trauma; and a history that is implausible, vague, changes with different tellings or is incompatible with the degree of injury or the child's developmental status. Radesky JS, Sugar NF. (2009) Femur fracture in an infant (Case Report). British Medical Journal. May 13;338:b1583. doi: 10.1136/bmj.b1583. Available at: http://www.bmj.com/content/ 338/bmj.b1583?tab=metrics

37. United Nations Children's Fund. Implementation Handbook for the Convention on the Rights of the Child. Fully Revised Third Edition, 2007, p. 379. Available at: http://www.unicef.org/publications/files/Implementation_Handbook_for_the_Convention_on_the_Rights_of_the_Child.pdf

The Advocate acknowledges the significant changes that have been made since Jake's death in care. A comprehensive review was conducted and subsequent recommendations have been made and implemented. Many of the deficiencies found in the services MSS provided have been addressed. The following recommendations emerge out of the Advocate's findings and reflect the Advocate's position on what still needs to change to ensure better outcomes for children in care.

Recommendation 1:

That the Ministry of Social Services complete a study that includes a review and analysis of the number of moves children and youth experience in out-of-home care and to provide a report to the Advocate. This study should include:

- **A random sample of children in emergency receiving homes, regular foster homes, group homes, and alternate care from the past two years;**
- **the number of moves and rationale for each move a child in the sample experienced; and**
- **the method of approval for the moves.**

Multiple moves in foster care is a persistent concern reported to the Advocate and found within many of our investigations. A study of this sort could provide MSS with the necessary information to thoroughly understand points of intervention to minimize the number of moves that children experience. In Jake's case, concerns were raised by the MSS worker and a foster mother related to the number of moves he experienced in a short time. These concerns were not addressed and Jake continued to experience additional moves that may have inhibited his development and well-being.

Recommendation 2:

That the Ministry of Social Services fully implement the software for the "Linkin" Information Database to allow for data collection to monitor the number of placements of children and youth in out-of-home care provincially.

As indicated earlier, research shows the detrimental effects of multiple moves on a child's development. MSS must be proactive in minimizing the number of moves a child experiences. If the MSS cannot monitor the number of placements of children in care, their situation is difficult or impossible to address.

Recommendation 3:

That the Government of Saskatchewan amend *The Child and Family Services Act* (or any legislation replacing this *Act*) or its regulations for the licensing of foster homes.

The Advocate has raised concerns about the safety of children in foster care for the last two decades, released a major report on overcrowding in foster homes in 2009, and has open recommendations on licensing.[38] Overcrowding in foster homes can overwhelm a caregiver's ability to keep children safe and provide the kind of nurturing environment they need to develop optimally.

Licensing provides accountability for both the Ministry of Social Services and for foster parents, improves public confidence, and helps ensure that the rights, interests and well-being of children are being respected. Alberta, Manitoba, and Ontario all license foster homes and licenses must be renewed on an annual basis. Saskatchewan already has a good model to follow with *The Child Care Act* and *The Child Care Regulations* for licensing and inspecting child care centres and homes. This legislation includes provisions around meeting children's developmental needs, child to staff ratios, the physical environment, including sleeping areas, health, safety, nutrition, hygiene and procedures for reporting incidents.

Recommendation 4:

That the Ministry of Social Services develop policy for new foster and group home resources that fall outside of the parameters of policy to ensure:

- **Assistant Deputy Minister approval is granted as recommended in the Joint Child Death Review; and**
- **appropriate operating procedures are developed and implemented prior to the opening of the resource.**

The Advocate does not endorse child welfare services that are not in accordance with MSS

policy. However the Advocate acknowledges the need to find unique solutions to the lack of foster home resources. The above requirements are necessary for MSS to achieve an equitable standard for accountability, and the safety and well-being of children.

Recommendation 5:

That the Ministry of Social Services conduct a provincial review of its open foster and group homes to ensure that homes are operating as per policy. For those that are operating outside of policy ensure:

- **Assistant Deputy Minister approval is granted as recommended in the Joint Child Death Review; and**
- **appropriate operating procedures are implemented.**

In response to Jake's death, a thorough review has already been completed in the Centre Service Area. An assessment of services in the remainder of the province is necessary to determine if the needs and best interests of the children are being met. MSS does conduct reviews on a representative sample of foster and group homes on an annual basis; however, this does not provide a complete picture of all environments where children are placed.

Recommendation 6:

That the Ministry of Social Services amend policy to conduct mandatory investigations of foster home incidents involving highly vulnerable children, including documentation and gathering information from collateral sources such as staff and other children in the home.

The Advocate understands that the policy on investigations of alleged abuse and neglect allows for significant discretion in whether or not to investigate. The Advocate is concerned that highly vulnerable children (children under three, non-verbal, developmentally delayed, severe medical needs, extreme behavioural issues) may not be afforded a high standard of review regarding injuries that occur in out-of-home care. In Jake's case, there were three different explanations of how his fractured femur occurred. It is imperative to interview relevant collateral sources to ensure due diligence in the matters of safety and protection.

Recommendation 7:

That the Ministry of Social Services require strict adherence to the "Maximum Number of Children in a Foster Home" and "Foster Home Review" policies in the Children's Services Manual.

The Advocate acknowledges that a child's immediate safety and protection is the priority and children may need emergency placements. However, these children still have a right to safety, security, and protection. Therefore, the number of children in a home must be kept to an acceptable number. While the Lawson Heights home was approved for 10 emergency placements of two weeks, some children stayed for much longer, compromising the level of care, supervision, and nurturing they received.

Adhering to these policies would ensure that decision to exceed the recommended number of placements in a home requires a new assessment of the foster parent's capacity and additional resources required, such as In-Home Support staff. ◆

38. See page 60 (6.13: It is the Time to Legislate and Regulate) and page 74 (Recommendation 31) in Saskatchewan Children's Advocate Office (former name). A Breach of Trust: An Investigation into Foster Home Overcrowding in the Saskatoon Service Centre. February 2009. Available at: http://saskadvocate.ca/media%20resources%20publications/Special%20Reports and pages 25 and 26 (6.3: Licensing and Accreditation of Residential Resources) in Children's Advocate Office (former name). Change for Children and Youth: A Submission to the Saskatchewan Child Welfare Review. June 2010. Published as part of the 2010 Annual Report, available at: http://saskadvocate.ca/media%20resources%20publications/Annual%20Reports

7. CONCLUDING REMARKS

It is rare in an investigation by the Advocate that the questions of why and how a child died cannot be answered. I share the dissatisfaction of Jake's family and his First Nations community with this situation. Jake spent the better part of his life in foster care. The many caregivers he had would have made it difficult for him to feel secure and to form healthy attachments. It was Jake's mother that was the most constant presence in his life.

The purpose of telling a story through the eyes of a child such as Jake is not to find fault, but to inform child welfare practices to ensure they respect the rights, best interests and well-being of children. Research on child development clearly shows that decisions on out-of-home placements must go beyond issues of physical safety and focus more on providing a loving and nurturing environment for children. Children will not be the recipients of this optimal experience, however, if they are constantly moving or exposed to high ratios of children to caregivers.

In the overall case planning, Jake appeared to be on the margins rather than at the centre of the systems providing him with services. His basic needs were met, including his need for physical health services as required. However, case planning for Jake was problematic, especially in the coordination of resources and services that were necessary for his developmental health. One of the goals of the *Saskatchewan Child and Family Agenda* is that children get a good start in life. This goal was originally stated as part of a recommendation in the *Child Welfare Review*, in November 2010, which envisioned the provincial government and a range of stakeholders prioritizing early childhood development.[39] Jake did not get the good start to which all are children are entitled.

While MSS has policies that ensure case planning for children occurs, it was unclear how MSS workers were guided and how Jake's plans were evaluated to ensure all of his unique needs were met while he was in foster care. Recent reports released by medical health officers from the Saskatoon Health Region on *Reducing Infant Mortality in Saskatoon Health Region*[40] and *Healthy Children, Healthy Families, Healthy Communities* (a child health status report),[41] are indicators that higher standards to promote children's developmental health and well-being are required in child welfare practice, and that families with young children require more prevention and early intervention services so that all children get a good start in life. It is important that MSS and health regions collaborate and use best practices to ensure effective case management for children in out-of-home care.

In our 2013 Annual Report,[42] we noted that despite some progress on the goal that children get a good start in life, we remain concerned that levels of public investment in young children prior to kindergarten remain low and many children are vulnerable. The Saskatoon Health Region's child health status report and the *Joint Task Force on Improving Education and Employment Outcomes for First Nations and Metis People*[43] both made recommendations for a provincial early childhood development strategy to improve outcomes for children and youth in Saskatchewan. We continue to advocate that the government develop more comprehensive early childhood and poverty reduction strategies to meet the goals of *The Child and Family Agenda*.

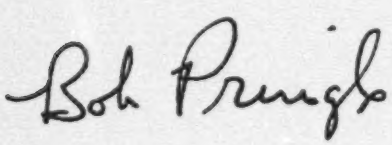
Also in our 2013 Annual Report, we published a summary of our investigation into the deaths of children born to mothers with addictions issues. This summary highlighted that child protection work is about safety for children, rebuilding

their families, and that children's well-being is dependent on the quality of services available to their parents. There are systemic gaps in services, particularly prevention services, for substance misusing mothers and their children. The Government's *Mental Health and Addictions Action Plan*, currently under development, and the legislative review of *The Child and Family Services Act* underway, are both providing many opportunities to find better ways to address the factors that put our children and youth at risk. These risk factors—poverty, mental illness, addictions, disabilities and family violence—were also relevant for Jake's family.

We acknowledge that MSS has made some positive changes in the years since Jake's death. As we move forward, the children must not be forgotten. The key to success is complying with the policies that are already in place as all children have the right to be in a stable, nurturing home and to be at the centre of case planning. We must keep moving in the right direction to ensure this happens.

I wish to thank all those who contributed to this investigation to restore Jake's voice to the extent possible. While it is too late for Jake, telling his story can help us make improvements in the child and youth-serving systems for children who come after him.

This report is dedicated to Jake and his family.



Bob Pringle

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40. Opondo J., Marko J., Medical Health Officer Report: Reducing Infant Mortality in Saskatoon Health Region. Saskatoon Health Region, 2012. Available at: http://www.communityview.ca/Catalogue/Document/Definition/1000278

41. Neudorf, C., Muhajarine, N., Marko, J. et al.. Healthy Children, Healthy Families, Healthy Communities: A report of the Chief Medical Health Officer. Saskatoon Health Region, 2012. Available at: http://www.communityview.ca/Catalogue/Document/Definition/1000282

42. Saskatchewan Advocate for Children and Youth. 2013 Annual Report. See pages 4, 30-33, 36-39. Available at: http://saskadvocate.ca/media%20resources%20publications/Annual%20Reports

43. Government of Saskatchewan, Federation of Saskatchewan Indian Nations. Voice, Vision and Leadership: A Place for All. Joint Task Force on Improving Education and Employment Outcomes for First Nations and Métis People. March 2013. Available at: www.jointtaskforce.ca

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